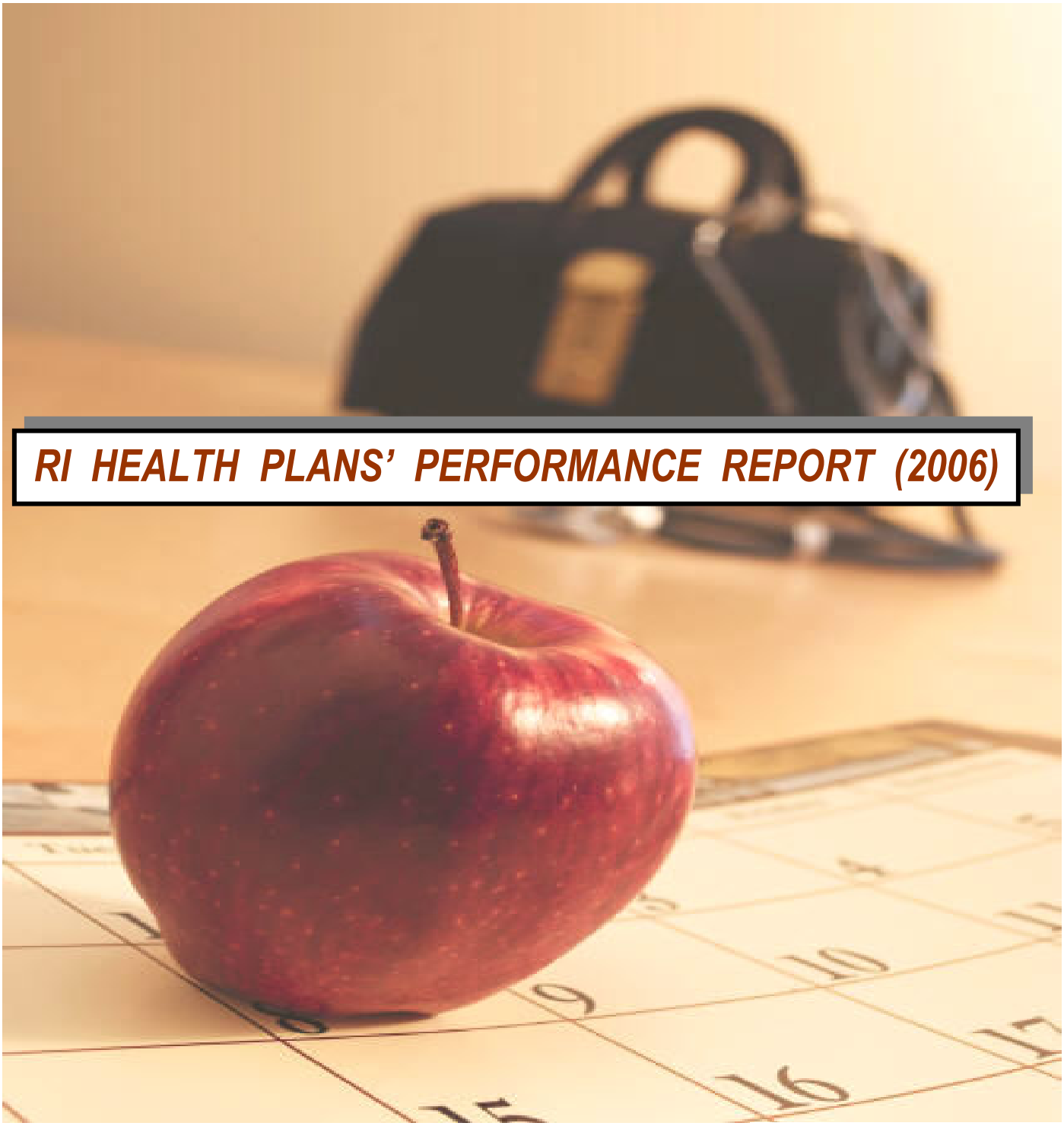

RI HEALTH PLANS' PERFORMANCE REPORT (2006)

RHODE ISLAND DEPARTMENT OF HEALTH

OFFICE OF THE HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

David Gifford, MD, MPH
Director of Health

Donald L. Carcieri
Governor of Rhode Island

Christopher F. Koller
Health Insurance Commissioner

September, 2008

To all Rhode Islanders:

We are pleased to present the ninth annual publication of the *Rhode Island Health Plans' Performance Report*. This Report, based on 2006 commercial health plan data submitted to the State Department of Health and Office of the Health Insurance Commissioner, provides information on 32 separate measures covering 8 dimensions of performance (i.e., enrollment, costs, utilization, prevention, screening, treatment, access, and satisfaction). Health plan performance is trended over time, compared to regional averages, and benchmarked to the best 10% of health plans nationally.

Public performance reporting is one of the most effective ways to focus healthcare improvement efforts, and a way to hold health plans accountable for the way services are provided. This information is used by healthcare programs to benchmark progress in improving the health status of Rhode Islanders, and may also guide policy-makers in their efforts to create a more 'balanced' healthcare delivery system promoting prevention and primary care.

In general, while both Blue Cross and Blue Shield of RI and United Healthcare of NE improved their scores on some quality measures in 2006, their relative performance lagged behind other New England plans overall. In addition, these two health plans have historically been less expensive than their N.E. counterparts, but their favorable price differentials narrowed significantly in 2006.

Care must be taken in drawing conclusions from the analyses, as populations, benefits and payments can vary among insurers. However, health plan practices do make a difference in performance and several measures in this report illustrate opportunities for plans to improve healthcare delivery in RI. For example, RI's 2006 commercial chlamydia screening rates were less than 40 percent, and antidepressant medication management rates were under 26 percent. These and other measures demonstrate the need for targeted primary care for early detection and disease management.

The Department of Health and Office of the Health Insurance Commissioner applaud RI's health plans' commitment to quality improvement, and their support in shaping RI's healthcare system to provide cost-effective, high quality healthcare services.

Sincerely,

David R. Gifford, MD, MPH
Director of Health

Christopher F. Koller
Health Insurance Commissioner

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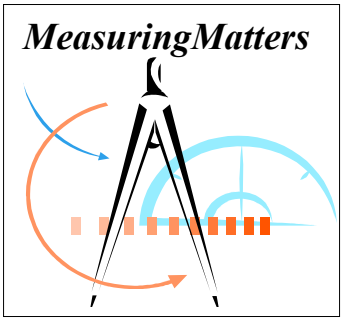

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Report is available online at www.health.ri.gov, and www.ohic.ri.gov

September, 2008

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I: EXECUTIVE SUMMARY

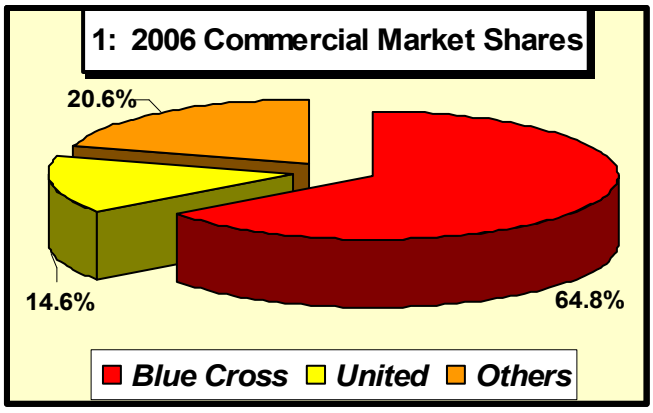
The 1996 Health Care Accessibility and Quality Assurance Act instituted the submission and analysis of health plan data in the state. This 2006 report fulfills the statutory reporting requirements of RIGL 23-17.13-3. It is the ninth edition to present health plan performance information, trended over time, and compared to regional averages, and national benchmarks.

With a small state population, few commercial underwriters, and the market dominance of Blue Cross & Blue Shield of RI (Blue Cross), most Rhode Islanders have limited choice of carrier. The lack of selective contracting also means that most plans deliver services through the same network of caregivers (i.e., the majority of physicians, hospitals and other providers participate in most, if not all plans).

Therefore, the value in publishing this information is primarily in promoting accountability of the industry, recognizing that the policies and practices of health plans - how they pay for and administer benefits - make a difference in how they operate. Purchasers deserve to know how well the plans are performing and policymakers need empirical evidence to set effective policy. Healthcare programs also need tools to benchmark progress in improving health status. An added benefit is that plan performance may improve simply by making the results public.

Some 342,039 Rhode Islanders were commercially insured in 2006, and this report analyzes the two largest health plans, which together covered over 79% of this population (i.e., Blue Cross and UnitedHealthcare of New England (United)). In all, eight separate dimensions of performance are evaluated, ranging from enrollment, costs, utilization and prevention, to screening, treatment, access, and satisfaction. A separate, companion publication, *The Health of RI's Health Insurers (2006)*, provides a financial analysis of the state's domiciled insurers.

RI's health insurance market is concentrated in two carriers (Chart 1). Blue Cross had a share of 64.8% and United controlled 14.6% of the commercial market. The remainder (20.6%), consisted of a host of smaller plans, all incorporated out-of-state.[1]



RI's two commercial health plans generally performed below average when their quality measures were compared to their New England cohorts in 2006 (Table 1).

1: 2006 Health Plan Quality Performance

Dimension/Measure	N.E. Averages	Relative to N.E. Averages [1]	
		Blue Cross	United
PREVENTION			
Childhood Immunization	82.3%	=	=
Adolescent Immunization	80.5%	-13%	-12%
Smokers Advised to Quit	78.5%	=	+7%
Smokers Advised on Meds.	52.4%	-5%	-9%
Smokers Advised on Methods	52.0%	=	+15%
SCREENING			
Colorectal Cancer Screening	64.9%	=	-6%
Breast Cancer Screening	78.8%	=	=
Cervical Cancer Screening	85.7%	=	=
Chlamydia Screening	44.4%	-11%	-12%
Diabetic Eye Exams	68.7%	-7%	-8%
Diabetic HbA1c Testing	91.5%	=	=
TREATMENT			
Beta Blocker Treatment	99.3%	=	=
Cholesterol Controlled	62.4%	-5%	-14%
Appropriate Asthma Meds.	91.6%	=	=
Antidepressant Med. Mgmt.	27.4%	-7%	-12%
ACCESS			
Follow-up for Mental Illness	85.2%	-7%	=
Prenatal Care	96.1%	=	-12%
Postpartum Care	85.5%	+5%	-15%
Well Child Visits	84.0%	=	=
Adolescent Well-Care Visits	60.0%	=	=

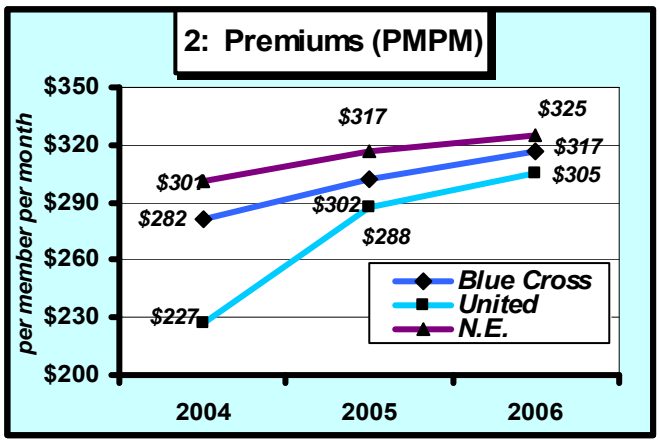
[1] *'=' indicates that the relative difference from the N.E. average was less than +/-5%*

For Blue Cross in 2006, 12 of its 20 quality measures were equivalent to the regional averages, one measure was better, and the remaining seven were worse than these comparables. However, on a trend basis, Blue Cross performed more favorably. From 2005 to 2006, 12 of its 20 quality measures remained unchanged, seven measures improved, and the remaining one declined in value.

For United in 2006, nine of its 20 quality measures were equivalent to the regional averages, two measures were better, and the remaining nine were worse than these comparables. On a trend basis, however, United also performed more favorably. From 2005 to 2006, 14 of its 20 quality measures remained unchanged, four measures improved, and the remaining two declined in value.

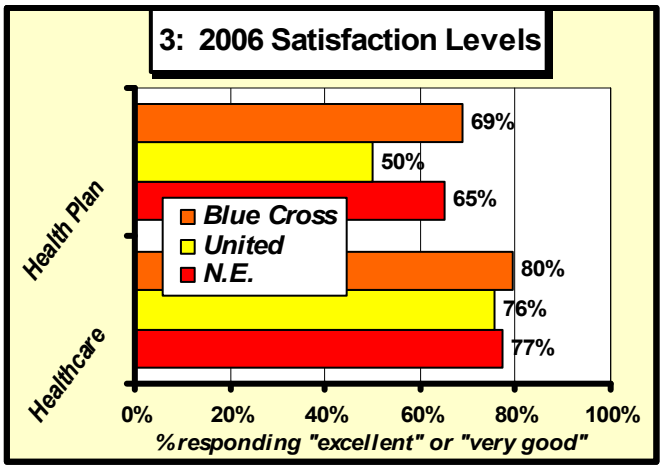
Irrespective of the favorable relative or trend performance of the plans, the weak absolute performances on some clinical measures is concerning. For example, *Chlamydia Screening* values of 40% and 39% (Blue Cross and United, respectively), and *Antidepressant Medication Management* values of 26% and 24%, respectively, underscore the need for further improvement in these areas.

Cost, in addition to quality, is the other determinant of value. For Rhode Islanders to receive value from their investment in health insurance, that coverage should be equivalent or less expensive and deliver the same or better quality services than elsewhere. Chart 2 graphs the average premiums paid (i.e., the cost to the purchasers) on a per member per month basis.



Rhode Islanders have historically paid less than their regional counterparts for health insurance, although that gap has narrowed. In 2004, Blue Cross was 6% less expensive than the New England average, while United was 24% less expensive. In 2006, those differences declined to –2% and –6%, respectively. This narrowing could reflect changes in reimbursement rates, increases in utilization, benefits or administrative costs (and profits) in RI relative to their New England counterparts.

Chart 3 graphs plan members' satisfaction with their health plans and with their healthcare.



Blue Cross' 2006 health plan satisfaction rate of 69% was 6% higher than the regional rate of 65%, while United's rate (50%) was 23% below that comparable. Healthcare satisfaction rates for the two insurers were not appreciably different from the New England value of 77%.

Interestingly, and in keeping with the experience in prior years, more members expressed satisfaction with their healthcare services than with their health plans, regardless of location.

All told, insurance coverage through these two carriers was not the relative bargain it was in previous years. RI's favorable price differential narrowed, so that premium costs approached the regional rates in 2006, and while some aspects of quality improved, it was relatively weak overall compared to other N.E. plans.

II: INTRODUCTION

Increasingly, the public, purchasers, providers, and policy-makers are seeking meaningful information about commercial health insurers. This report provides the most comprehensive public source of data on plans certified to operate in Rhode Island.[1]

Consumers and purchasers may use this information to make informed choices among competing plans or to understand their chosen plan better. The plans themselves have comparative statistics to identify and focus improvement efforts, and policymakers may use this information to support their decision-making. Lastly, healthcare programs may use these data to benchmark their own performances.

A. Background

Not all health insurers are identical. They differ in how they keep members well and how they care for them when they are ill, even though their provider networks may be similar. They also differ in how they provide access to and deliver services. Most Rhode Islanders receive their health coverage through the two commercial plans in this report, so learning about how they perform is essential to determining if value is received from the premium dollars expended.

Consequently, in response to this need for information, the Rhode Island General Assembly passed the Health Care Accessibility and Quality Assurance Act (RIGL 23-17.13) in 1996. One stipulation of this law was a requirement that health plans submit performance data to the Department of Health (HEALTH). This report fulfills the statutory reporting requirements of the Act.

To consumers, the quality, and access to care provided by a plan may affect their health. To employers, these same issues may influence worker absenteeism, productivity and the company's personnel costs.

The *RI Health Plans' Performance Report (2006)* is the ninth annual publication of this information. For more assistance in choosing a particular commercial health plan, readers are referred to: http://hprc.ncqa.org/.

B. How to Use This Information

The report is divided into sections containing similar dimensions of performance. Section III examines enrollment and market share. Section IV provides cost information, and section V compares utilization statistics. Section VI looks at prevention measures, and section VII gives screening information. Section VIII presents treatment statistics and section IX shows access measures. Lastly, section X provides the results of member satisfaction surveys. Whenever possible, regional (New England) averages and national 90th percentile values are provided to assess the plans' performances relative to these benchmarks.

This report examines commercial health plans only, it does not include Medicaid or Medicare HMO plans. Information on the financial performance of RI's health insurers is presented in a companion publication, *The Health of RI's Health Insurers (2006)*.

Different users will use this information in different ways, however, the following guidelines should help improve its utility for everyone.

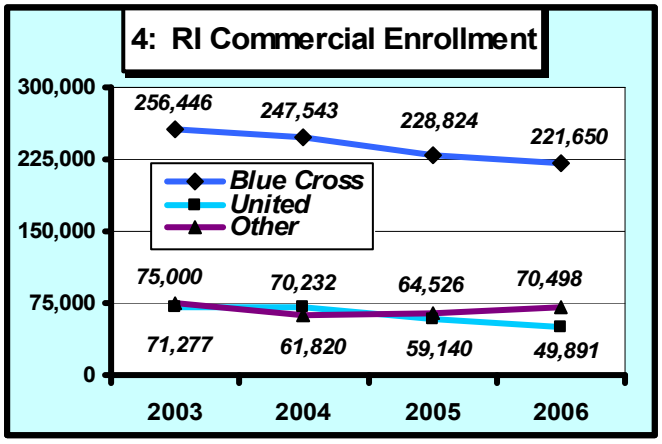
- **No one measure in and of itself can accurately reflect health plan performance.** Therefore, the statistics should be viewed in combination and not in isolation.
- **Readers should focus on large differences between health plans** that are less likely to be caused by random chance. When comparing statewide performance to the regional values or national benchmarks, differences less than +/-5% usually do not signify any meaningful variations.[2]
- **Readers should recognize there may be reasons why results vary other than differences in quality or administration.** Every plan enrolls a distinct set of members with unique demographic characteristics that could affect performance (e.g., age, health status, race/ethnicity, socioeconomic status). In addition, differences in covered benefits may also influence outcomes and should be a topic consumers cover when selecting a health plan.

- **This report examines all types of commercial health plans (i.e., HMO, POS and PPO).** HMOs are legally defined and, generally, use restricted networks to deliver care through the member's primary care provider. In addition, they may employ a variety of managed care techniques[3] to coordinate care and control costs. As other plans employ these same techniques, and as the popularity of traditionally-defined HMOs wanes, this distinction becomes less apparent and important.
- **This report excludes plans with fewer than 10,000 RI members.**[1] These insurers are fairly minor competitors in the RI marketplace at this time and, to reduce their reporting burden, they are exempt from filing. Also, given their smaller market shares, they do not influence providers' practices to any significant extent.
- **Comparable data** (i.e., the New England averages and the national 90th percentile values) are from other commercial health plans included in Quality Compass (National Committee for Quality Assurance). In the text, reference may be made to U.S. or national benchmarks. Those benchmarks are the cutoff values for the best-performing 10% of health plans nationally (Appendix E). Therefore, these benchmarks are the 90th percentile national values[4] (e.g., the 2006 *Childhood Immunization* benchmark of 87.7% means that 90% of plans across the country had values below 87.7%, and 10% had values above 87.7%).

III: ENROLLMENT

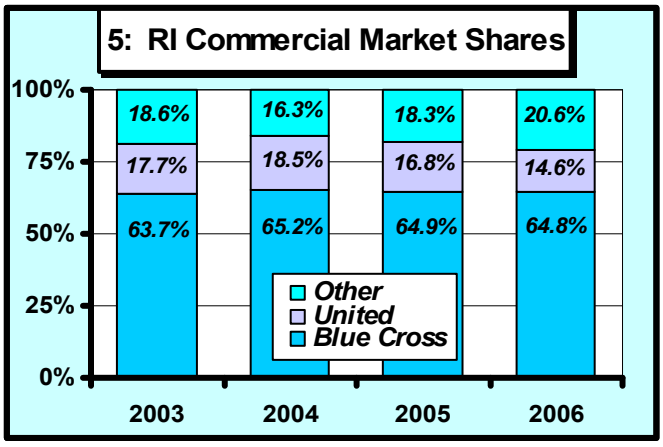
This section compares health plan membership information and market shares. Included is the fully-insured commercial book-of-business only, and not any self-insured members for which the plans provide third party administrators' (TPA) services.

A. RI Enrollment is the computed RI resident enrollment in a health plan for the full year. Increasing enrollment over time is important both in terms of achieving economies of scale and increasing market share.



Blue Cross remained, by far, the largest commercial carrier with 221,650 fully-insured RI members, and United followed with 49,891 RI members. Total RI commercial enrollment fell every year, from 402,723 in 2004 to 342,039 in 2006, reflecting the general decline in insurance coverage and the switch to self-insurance by some larger companies.

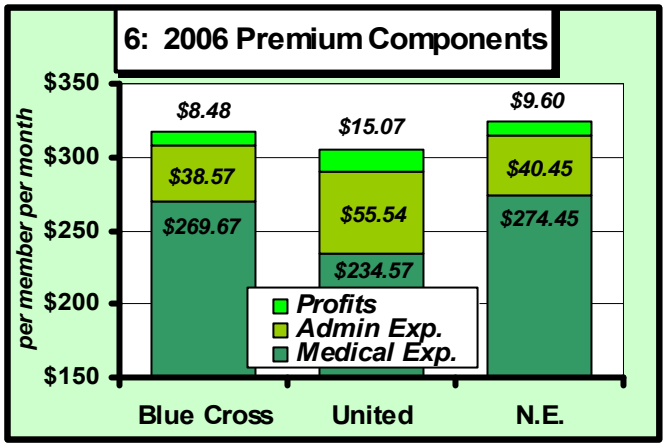
B. RI Market Shares calculates each plan's percentage of the total RI fully-insured enrollment (Chart 5). In many respects, market share is more important than simple enrollment (although the two are related). It is possible in a shrinking market for a plan's enrollment to decline while its market share increases. Market share, to a large extent, determines how aggressively a plan can negotiate its provider contracts, rates and commissions.



Blue Cross controlled 64.8% of the domestic commercial market in 2006, and this share has been relatively steady since 2004. United's 2006 share was 14.6%, and this has eroded since 2004.

IV: COSTS

This section compares health plan cost information. Chart 6 presents the average costs of the healthcare coverage in 2006, as well as the amounts spent on healthcare services, administrative expenses, and the remaining profits (on a per member per month basis).[5]



In 2006, both Blue Cross and United had monthly premiums below the New England rate ($316.72, and $305.18 versus $324.50, respectively). However, care should be exercised in interpreting this statistic. One insurer may be less expensive than another, but that doesn't necessarily mean it provides better value.

Different insurers may sell health plans with different benefits, co-pays or deductibles at different prices. Thus, the total healthcare costs for a member in a less expensive plan may actually be greater than a more expensive plan that has fewer co-pays, lower deductibles, or more covered services the member needs.

Medical expenses are the amounts plans spend on healthcare services for their members. Consumers generally favor higher medical expenses (all else being equal), because it indicates more of their premium dollars going into their healthcare. However, lower medical expenses do not necessarily imply that an insurer restricts access to services. Lower expenses could instead mean that a plan's members are less ill, that the plan sells less expensive benefit plans with more cost sharing, that the plan is more effective at managing care for its members, or that its reimbursement rates to providers are lower than its competitors.

In 2006, both Blue Cross and United had monthly medical expenses below the New England rate ($269.67, and $234.57 versus $274.45, respectively).

Administrative expenses are the amounts spent on operating the health plan, and marketing its products. Many administrative expenses are fixed, so controlling them is essential to maximizing profits. Generally, consumers favor lower administrative expenses as a matter of course, expecting that these monies could instead go into direct services to members.

In 2006, Blue Cross' administrative expenses of $38.57 were 4.6% less than the New England rate of $40.45, while United's expenses ($55.54) were 37% above that comparable.

Profits are the monthly net amounts generated per member from underwriting the commercial book-of-business after all associated expenses have been paid. Profits are critical, even for non-profit insurers (e.g., Blue Cross), because they allow the organization to remain solvent (i.e., add to the reserves), to increase marketing, and to invest in new information systems. 'Excessive' profits, however defined, may be a particular risk in what is essentially a two insurer market such as RI.

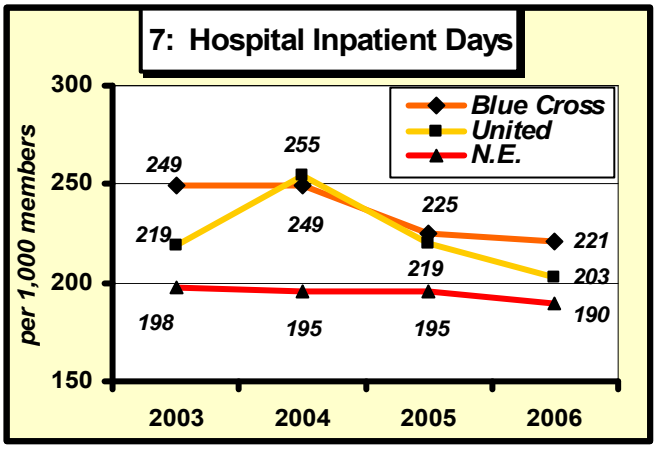
In 2006, Blue Cross' PMPM profits of $8.48 were 12% less than the New England rate of $9.06, while United's profits of $15.07 were 57% above that comparable.

V: UTILIZATION

This section gives information[6] on the services utilized by members in a health plan.

A. Hospital Inpatient Days are the average number of acute-care hospital days used by every 1,000 members in a plan (Chart 7). Excluded are substance abuse, mental health and nursery days. Inpatient hospital expenses comprise 30%-40% of most insurers' medical

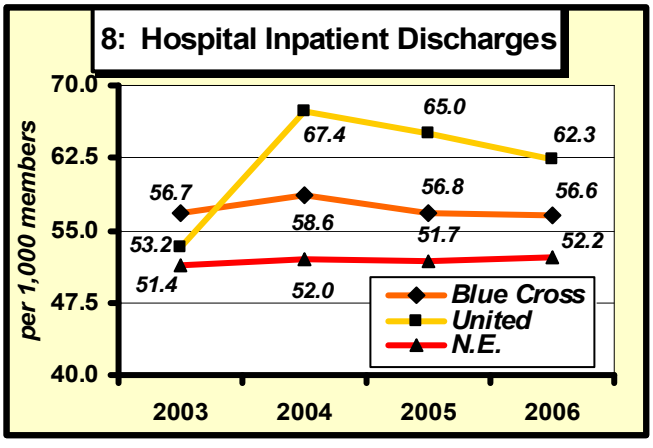
expenses, and while this merits attention, there is no desired trend or benchmark for this measure.



RI's two insurers consistently had higher hospital day rates than their regional counterparts, although the differentials narrowed since 2003. In 2006, Blue Cross was 16% above the New England average, and United was 7% above that comparable.

Relatively high hospital day rates are neither inherently favorable nor unfavorable, therefore, benchmarking to a desired goal is not possible. Assuming that all hospital utilization is appropriate, then high day rates may be acceptable given a sicker population requiring more services. However, relatively high day rates may also indicate the lack of preventive services or poor care for chronic diseases.

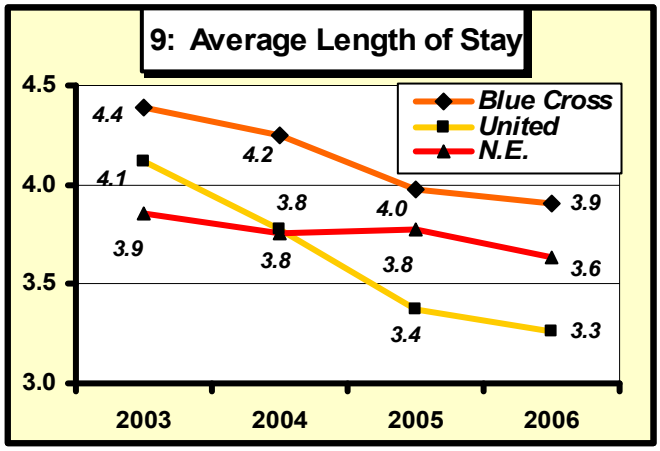
B. Hospital Inpatient Discharges are the average number of acute-care hospital discharges (excluding substance abuse, mental health and nursery discharges) used per 1,000 members in a plan (Chart 8). There is no desired trend or benchmark for this measure.



Again, RI's two insurers consistently had higher hospital discharge rates than their regional counterparts, although the differentials narrowed since 2004. In 2006, Blue Cross' rate was 8% above the New England average, and United was 19% above that comparable.

As with day use rates, relatively high discharge rates are neither inherently favorable nor unfavorable. Therefore, benchmarking to a desired goal is not possible. Assuming that all hospital utilization is appropriate, then high discharge rates may be acceptable given a sicker population requiring more services. However, relatively high discharge rates may indicate the lack of preventive services or poor care for chronic diseases.

C. Average Length of Stay is the average number of inpatient days for each acute-care hospital discharge (Chart 9). There is no desired trend or benchmark for this measure.

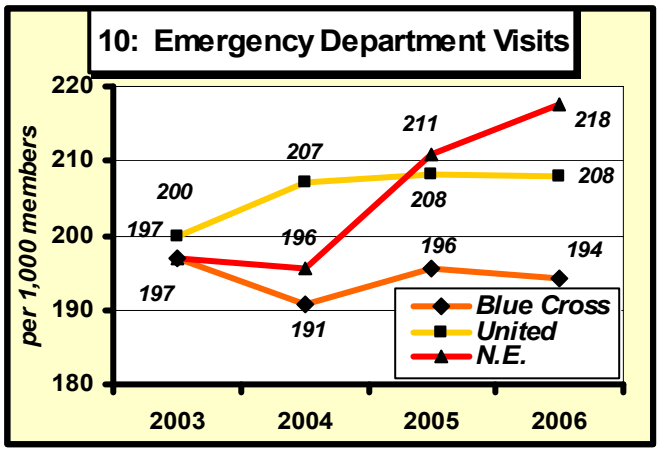


Blue Cross and United both started the period with average length of stays above the New England average in 2003. By 2006, Blue Cross was 7% greater than the N.E. value, while United reduced its length of stay to 10% below that comparable.

Again, higher length of stay values are neither inherently desirable nor undesirable without case-mix adjusting the different patient populations. A longer length of stay may be warranted because of the case-mix complexity or demographics of a particular plan's members requiring more intensive inpatient services.

D. Emergency Department Visits are the number of visits to hospital emergency departments (excluding behavioral health visits and those that resulted in the patient being admitted) for every 1,000 members in a plan (Chart 10).

Emergency departments are often used to provide primary or secondary care that could be delivered more inexpensively and more appropriately elsewhere. Therefore, lower values on this measure are preferred.

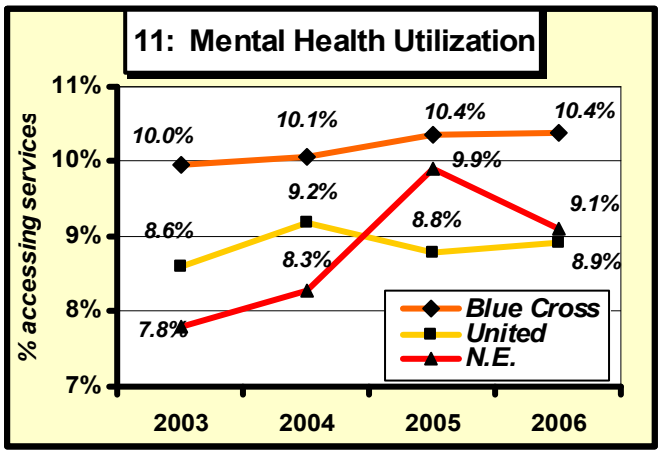


Blue Cross outperformed United by –7% on this measure in 2006. And, even though the absolute ED utilization rates were fairly steady since 2004, Blue Cross and United both made significant relative improvements on this measure as the regional rates increased. They started the period either equal to or higher than the N.E. rate in 2003, and ended below that comparable in 2006 (11% and 5% lower for Blue Cross and United, respectively).

However, regardless of these favorable relative gains, neither plan approached the national benchmark in 2006. Blue Cross was 40% above the benchmark value of 138, and United was 50% above that value. RI clearly needs to expand its primary care delivery system to reduce inappropriate ED utilization.

E. Mental Health Utilization is the percentage of members with a mental health benefit that received any mental health treatment (i.e., inpatient, intermediate or ambulatory) during the year (Chart 11).

Mental illness is widely under-diagnosed and a major quality-of-life determinant, thus an argument could be made that trends should be increasing. However, without knowing the respective disease incidences, one cannot conclude that a higher value is necessarily preferable to a lower one. Therefore, there is no desired trend or benchmark for this measure.



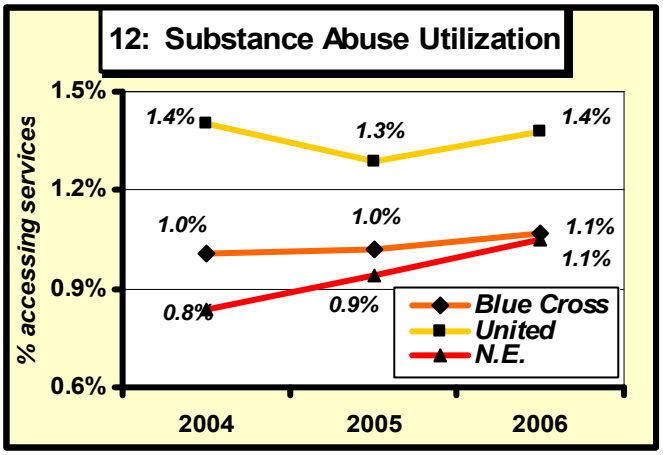
Absolute values for both plans rose slightly over the period as they did in New England. Blue Cross maintained higher values than United (and N.E.), while United started the period in 2003 above N.E., and ended slightly below that comparable. In 2006, Blue Cross ended 14% above the regional average, while United was 2.1% below that comparable.

Without knowing the comparative mental illness incidence rates, the actual utilization of services, and outcomes, one cannot determine if mental health treatment was any better in one plan than another (or in RI than elsewhere). One may only state that a greater percentage of members in a plan with a higher value accessed these services (at least once).

F. Substance Abuse Utilization is the percentage of members filing an alcohol and/or other drug claim for substance abuse treatment services (i.e., inpatient, day or outpatient) during the year (Chart 12).

Substance abuse is very expensive in terms of personal and societal costs. Treatment, even considering recidivism rates, remains the most cost-effective response to this disease. However, as with mental health, without knowing the respective disease incidences, one cannot con-

clude that a higher value is necessarily preferable to a lower one. Therefore, there is no desired trend or benchmark for this measure.



Absolute values for both plans were flat or rose slightly over the period while those in New England increased markedly. United maintained higher values than Blue Cross (and N.E.), while Blue Cross started the period in 2004 above N.E., that gap narrowed significantly. In 2006, Blue Cross was essentially equivalent to the regional average, while United was 31% above that comparable.

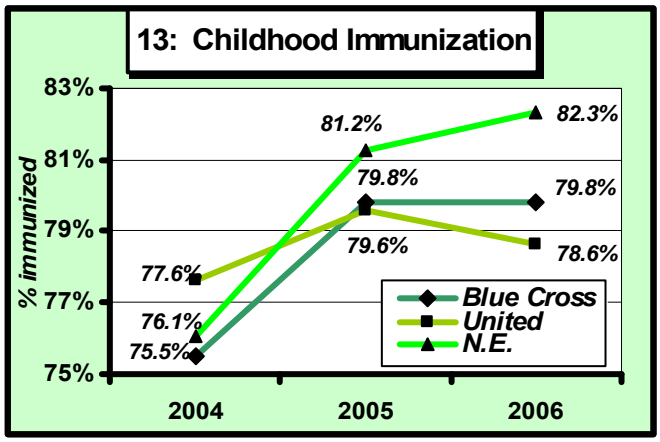
However, and again as with mental health, without knowing the comparative substance abuse incidence rates, the actual utilization of services, and outcomes, one cannot conclude that substance abuse treatment was any better in one plan than another (or in RI than elsewhere). One may only state that a greater percentage of members in a plan with a higher value accessed these services (at least once).

V: PREVENTION

This section contains measures[6] that look at how effectively a plan delivers preventive services to keep its members healthy.

A. Childhood Immunization is the percentage of children in the plan that received the appropriate immunizations by age 2 (Chart 13).[7] As immunization protects children against vaccine-preventable and sometimes devastating disease, it is one of the most cost-effective examples of high-quality primary care. Therefore, higher values on this measure are preferred.

To enhance immunization levels in Rhode Island, HEALTH's Immunization Program[8] tracks this measure and provides vaccines consistent with the CDC's *Recommended Childhood and Adolescent Immunization Schedule,*[9] free of charge to pediatricians and other selected providers. The Immunization Program has adopted a target of 85% compliance on this measure (by 2010).

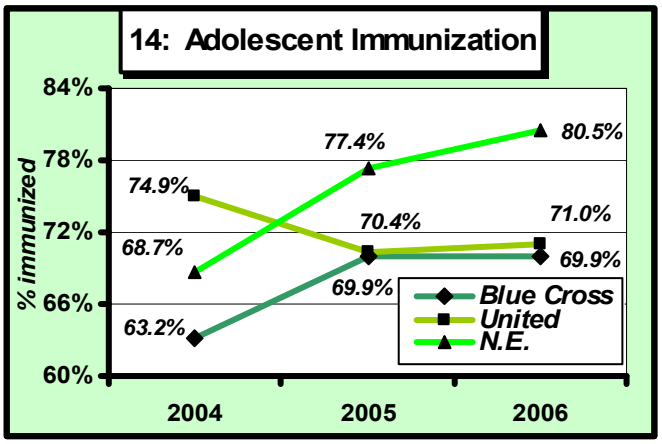


Absolute values for both plans rose in 2005, and then leveled off or declined, while the N.E. average increased. In 2006, neither Blue Cross nor United significantly differed from the regional value (i.e., less than –5% variances). Regardless of the fact that both plans improved their performances over time, neither plan approached the national benchmark 87.7% in 2006. Blue Cross was 9% below the benchmark, and United was 10% below that cutoff.

With over 20% of RI's commercially insured children in both plans not receiving their vaccinations within the recommended timeframes, there needs to be renewed effort on the part of payors, policy makers and providers to reach this population.

B. Adolescent Immunization is the percentage of adolescents (13 years of age) who received the appropriate immunizations (Chart 14).[10] Adolescent immunizations are a proven defense against common, serious and transmissible diseases such as Hepatitis B, measles, mumps and rubella, so higher values on this measure are preferred.

Consistent with the *Childhood Immunization* rates, HEALTH's Immunization Program monitors this measure and provides the appropriate adolescent vaccines free of charge to pediatricians and other select providers. The Immunization Program has adopted a target of 85% compliance on this measure (by 2010).

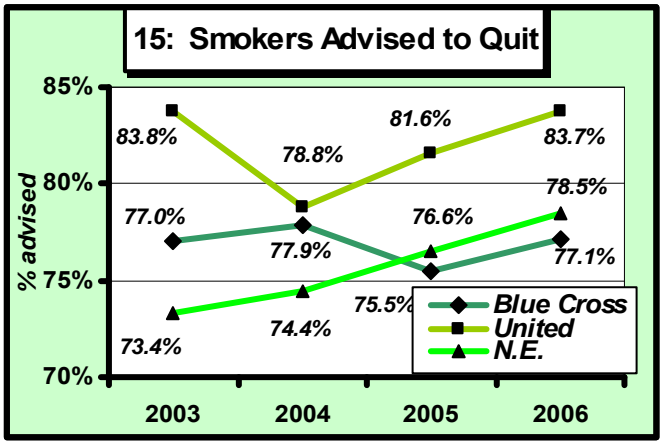


The performances of the two health plans was mixed on this measure. Absolute values for Blue Cross rose over the period while those for United declined into 2005, then leveled off. N.E. values improved steadily and significantly over the period, causing the plans to fare relatively poorly. In 2006, Blue Cross was 13% below the regional average, and United was 12% below that comparable. Neither plan approached the national benchmark of 81.3% in 2006. Blue Cross was 14% below the benchmark, and United was 13% below that cutoff.

Similar to the childhood immunization situation, there needs to be continued progress on the part of payors, policy-makers and providers in getting the unserved ~30% of the populations in these plans immunized within the recommended timeframes.

C. Smokers Advised to Quit is the percentage of members (ages 18+) who are smokers and who received advice to quit within the past year (Chart 15).[11] An estimated 21% of adult Americans are smokers and it is the leading preventable cause of death in the nation (~438,000 deaths per year). Seventy percent of smokers are interested in stopping, and getting advice to quit is associated with a 30% increase in the number of people who succeed. Therefore, higher values on this measure are preferred.

This measure is tracked by HEALTH's Tobacco Control Program[12] as part of its efforts to reduce smoking in the state. Tobacco Control has adopted a target level of 95% compliance on this measure.



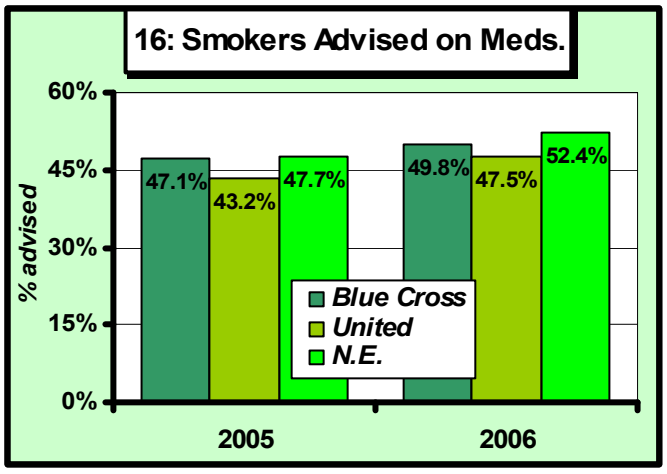
United outperformed Blue Cross by +9% on this measure in 2006. United made steady improvement since 2004, while Blue Cross' values were essentially flat. The plans' relative performance also varied. In 2006, Blue Cross was similar to the regional average (i.e., less than a –5% variance), while United was 7% above that comparable. United was among the best 10% of health plans nationally on this measure in 2006, and Blue Cross was not significantly below the benchmark of 80.2% (i.e., less than a -5% variance).

Given the marginal cost of providing medical advice on smoking, further gains should be made on a statewide basis when 23% of Blue Cross' and 16% of United's affected populations were not properly advised to quit.

D. Smokers Advised on Cessation Medications is the percentage of members (ages 18+) who are smokers and who received advice on cessation medications (Chart 16).[11] Research has shown that provider advice on cessation medications doubles quit rates. Therefore, higher values on this measure are preferred.

This is another measure tracked by HEALTH's Tobacco Control Program.[12] Tobacco Control

has adopted a target level of 95% compliance on this measure.

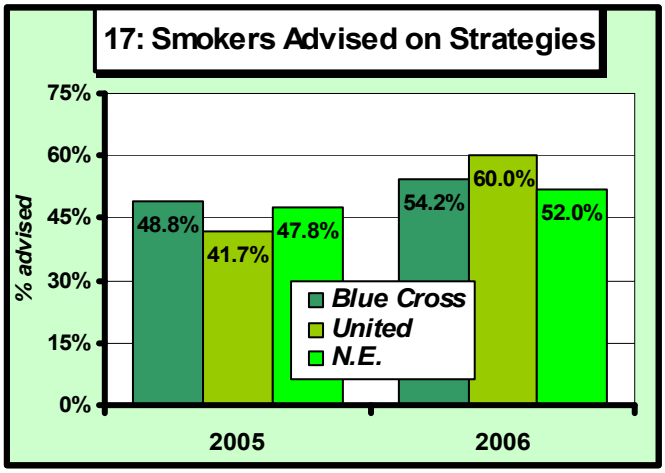


Even though both plans improved their absolute values in 2006, their relative performances lagged the N.E. experience in 2006. Blue Cross was 5% below the regional average, while United was 9% below that comparable. Both plans were also below the national benchmark of 53% in 2006 (6% lower for Blue Cross, and 10% lower for United).

Again, given the marginal cost of providing medical advice on smoking, further gains should be made on a statewide basis when over 50% of the affected populations in these plans were not properly advised on cessation medications.

E. Smokers Advised on Cessation Strategies is the percentage of members (ages 18+) who are smokers and who received advice on cessation strategies (Chart 17).[11] Due to the effectiveness of provider advice in routine clinical encounters, it is important that smokers are consistently advised on a combination of cessation strategies, including counseling and pharmacotherapy. Therefore, higher values on this measure are preferred.

This is a third measure tracked by HEALTH's Tobacco Control Program.[12] Tobacco Control has adopted a target level of 95% compliance on this measure.



United outperformed Blue Cross by +11% on this measure in 2006. Both plans posted favorable absolute gains in 2006, with Blue Cross ending the period essentially equivalent to the regional value and United 15% above that comparable. Both Blue Cross and United were among the best 10% of health plans nationally on this measure in 2006, and United performed significantly better than the U.S. benchmark of 52.8% (i.e., 14% above that value).

Once again. given the marginal cost of providing medical advice on smoking, further gains should be made on a statewide basis when 45% of Blue Cross' and 40% of United's affected populations were not properly advised on cessation strategies.

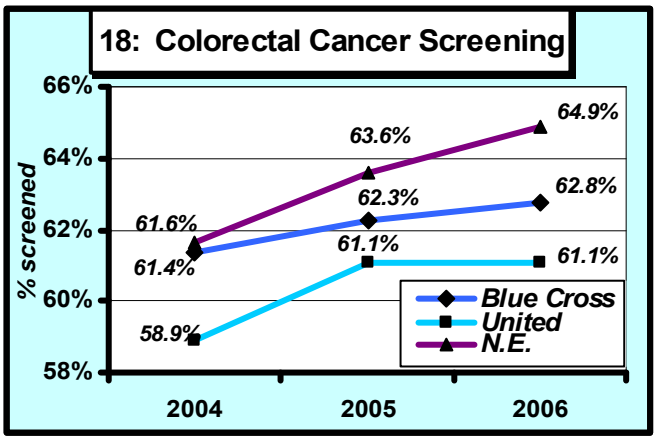
VI: SCREENING

This section contains information[6] on how effectively a health plan screens its members for possible medical problems. Screening is the second most cost-effective activity (behind prevention) to reduce the adverse effects of disease.

A. Colorectal Cancer Screening is the percentage of members (ages 50-80) who were screened for colorectal cancer (Chart 18). Colorectal cancer is the second leading cause of cancer related deaths in the country (~56,000 deaths annually). Early stages of the disease are often asymptomatic so regular screening becomes the only way to detect it. In addition, colorectal screening can prevent the disease

through removal of pre-malignant polyps, so higher values on this measure are preferred.

This measure is tracked by HEALTH's Comprehensive Cancer Control Program[13] as part of its efforts to increase colorectal cancer screening in the state. The Program has adopted a target level of 85% compliance on this measure.

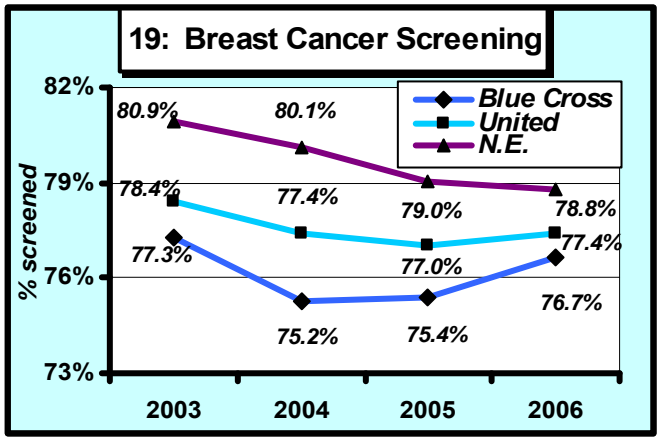


Absolute values for both plans rose slightly over the period, but the N.E. values improved at a greater pace, causing the plans to fare less well. In 2006, Blue Cross was not significantly different from the regional average (i.e., less than a –5% variance), but United was 6% below that comparable. Likewise, in 2006, Blue Cross was not significantly different from the U.S. benchmark of 65.1% (i.e., less than a –5% variance), but United was 6% below that threshold.

Clearly there needs to be further improvement in this measure when over 37% of the affected populations in these plans remain unscreened.

B. Breast Cancer Screening is the percentage of women members (ages 52-69) who had a mammogram within the last two years (Chart 19). Breast cancer is the second most prevalent cancer among U.S. women (>211,000 new cases per year), and mammography screening reduces mortality 30% for women 50 and older. Higher values on this measure are therefore preferred.

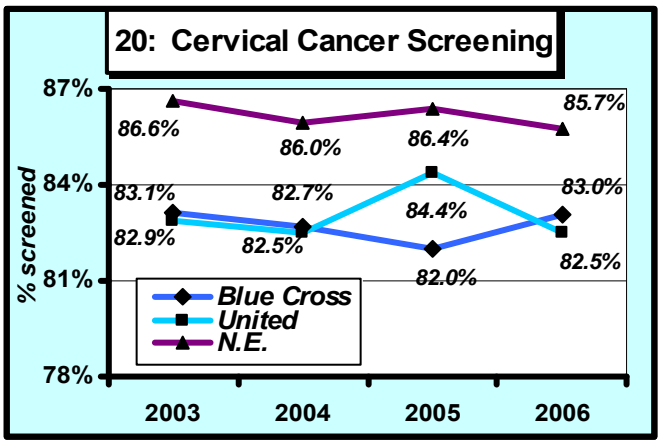
This measure is tracked by HEALTH's Women's Cancer Screening Program,[14] which provides breast and cervical cancer screening to RI uninsured, program-eligible women. Because the Program is targeted to the uninsured, it does not have an adopted target level of compliance for this measure, which reflects only the commercially insured population.



Breast cancer screening levels approached the regional values, not because of any great improvement in absolute performances, but from declines in the N.E. rates. In 2006, both plans finished essentially equivalent to the N.E. average (i.e., less than -5% variances), and the national benchmark of 80.1%.

C. Cervical Cancer Screening is the percentage of women (ages 21-64) who received a Pap test within three years (Chart 20). Cervical cancer is one of the most successfully treated cancers when diagnosed early, and screening has led to declining mortality rates over the past 30 years. Nonetheless, an estimated 10,000 new cases are diagnosed each year resulting in nearly 4,000 deaths nationally; therefore, higher values on this measure are preferred.

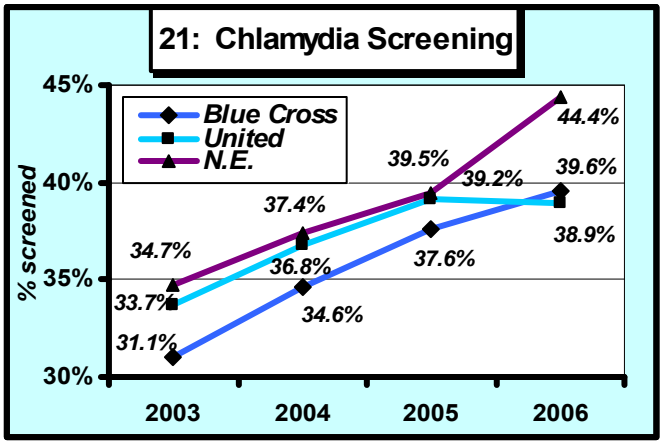
This is another measure tracked by HEALTH's Women's Cancer Screening Program,[14] which provides breast and cervical cancer screening to RI uninsured, program-eligible women. Because the Program is targeted to the uninsured, it does not have an adopted target level of compliance for this measure, which reflects only the commercially insured population.



Cervical cancer screening rates at both plans tracked similarly, except in 2005, but they finished the period statistically equivalent to each other. Likewise, neither plan deviated substiantially from the regional average in 2006 (i.e., less than –5% variances). The U.S. benchmark was 87.1% in 2006, and Blue Cross was not markedly below that value, while United was 5% less than that cutoff.

D. Chlamydia Screening is the percentage of (sexually active) women members (ages 16-25) having a chlamydia test during the year (Chart 21). Chlamydia is the most common sexually transmitted disease (STD) in the U.S. (~3 million infected annually), and a leading cause of infertility. Screening is essential because the disease is usually asymptomatic and easily treated with antibiotics, so higher values on this measure are preferred.

HEALTH's STD Prevention and Control Program[15] follows this measure to monitor Chlamydia screening in the commercially insured population. Because the Program targets the under/uninsured, it does not have an adopted target level of compliance for this measure (which reflects the commercially insured population only).

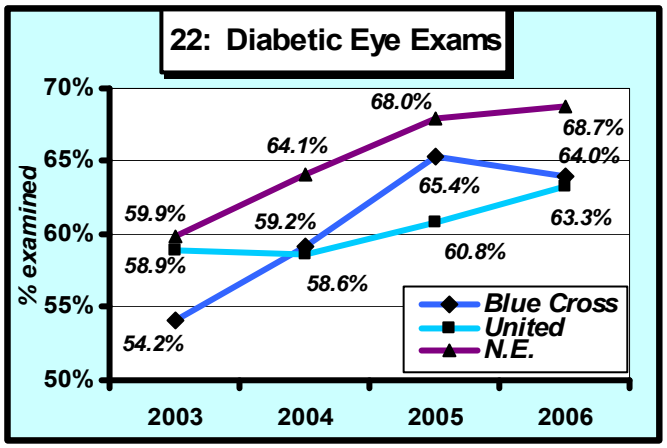


Both health plans improved their performances on this measure, but the N.E. average increased 12% in 2006, compromising their relative positions. That year, Blue Cross ended 11% below the regional average, while United was 12% below that comparable. The U.S. benchmark was 48.6% in 2006, and both plans were significantly below that value (i.e., 19% lower for Blue Cross, and 20% lower for United).

Regardless of recent improvements in chlamydia screening rates, the low absolute values illustrate the need for further improvement as over 60% of the affected populations in these plans are not being screened.

E. Diabetic Eye Exams is the percentage of diabetic members (ages 18-75) that received an eye exam for retinal disease (Chart 22). Diabetes is the leading cause of adult blindness in the US, so regular examinations are important to diagnose and treat problems as early as possible. Therefore, higher values on this measure are preferred.

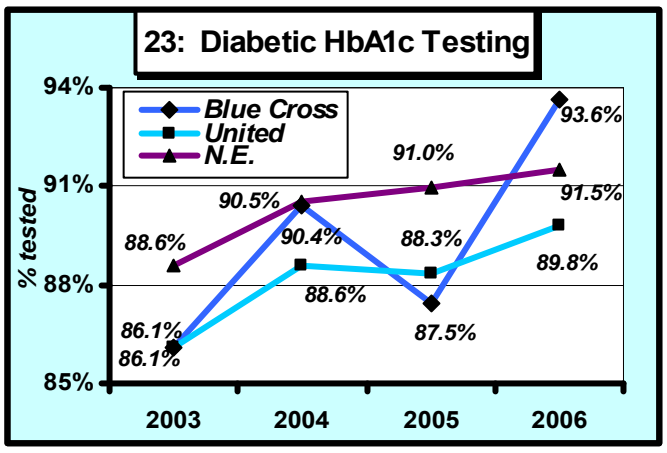
This is a measure tracked by HEALTH's Diabetes Prevention and Control Program[16] as part of its efforts to reduce the incidence of and improve the quality of care for the disease. The Program has adopted a target goal of 85% for diabetic eye exam screening.



Both plans generally improved their performances on this measure, but the N.E. averages continued to outpace the local values. In 2006, Blue Cross ended 7% below the N.E. average, and United was 8% below that comparable. The U.S. benchmark was 71.2% in 2006, and both plans were below that value (i.e., 10% lower for Blue Cross, and 11% lower for United).

F. Diabetic HbA1c Testing is the percentage of diabetic members (ages 18-75) who had their hemoglobin A1c tested (Chart 23). Diabetes is one of the most costly (~$100 billion annually), and prevalent diseases in the U.S. (~17 million persons), causing 20% of all deaths in adults over 25. In addition, its complications (amputations, kidney failure, blindness) may be prevented if diagnosed and addressed early, so higher values on this measure are preferred.

This is another measure tracked by HEALTH's Diabetes Prevention and Control Program and it has adopted a target goal of 95% for HbA1c testing.



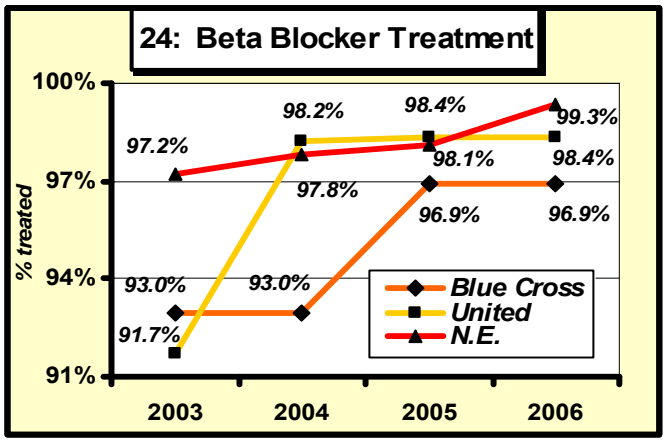
The plans' performances varied greatly on this measure. Blue Cross' values fluctuated both in absolute and relative terms while United posted fairly consistent increases. Neither plan deviated significantly from the regional average in 2006 (i.e., less than +/–5% variances). The U.S. benchmark was 92.9% in 2006, and Blue Cross was among the best 10% of health plans nationally, while United was not substantially below that cutoff (i.e., 3% lower).

VII: TREATMENT

This section contains measures[6] that look at the clinical quality of care provided within a health plan, how well it treats its members who are ill and whether that care is effectively managing the disease.

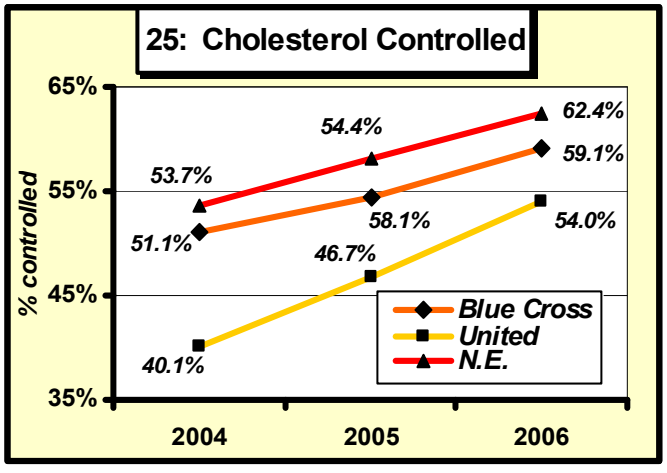
A. Beta Blocker Treatment is the percentage of members (ages 35+) discharged after an acute myocardial infarction (AMI) who received an outpatient beta blocker prescription at discharge (Chart 24). Given the prevalence and costs of heart disease in the U.S. (i.e., >1 million AMIs at a cost of ~$111 billion, annually), beta blocker therapy has proven an effective medical treatment to reduce the risk of having another attack. Higher values on this measure are, therefore, preferred.

This measure is tracked by HEALTH's Heart Disease and Stroke Prevention Program[17] to improve the current heart disease and stroke prevention system in RI. The Program has adopted a target level of 100% compliance on this measure.



RI plans performed quite well on this measure, increasing their values over time, and ending essentially equivalent to both the regional average and the national benchmark of 100% in 2006.

B. Cholesterol Controlled is the percentage of members (ages 18-75) discharged after an acute cardiac event whose low-density lipoprotein component of blood cholesterol (LDL-C) was controlled to <100mg/dL (Chart 25). Coronary artery disease (CAD) affects ~15 million Americans and is the leading cause of heart-related mortality in the U.S. Total blood cholesterol is directly related to CAD, so management of this causative factor is important in controlling the disease. Therefore, higher values on this measure are preferred.

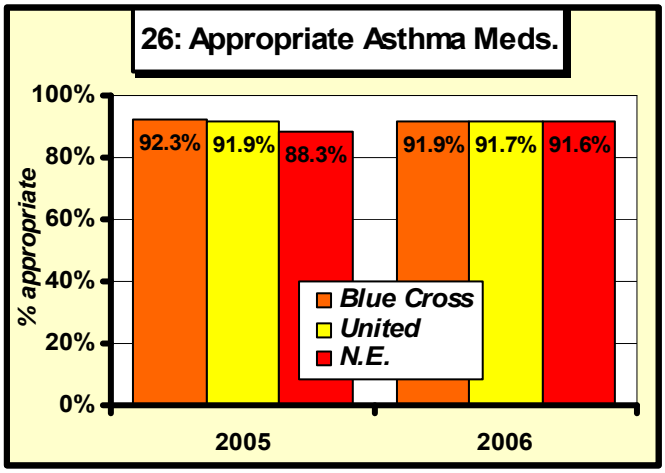


Blue Cross outperformed United by +9% on this measure in 2006. Even though both plans improved their absolute values, their relative performances were weak. In 2006, Blue Cross was –5% below the regional average, and United was –14% below that comparable. The national benchmark was 66.2% in 2006, and Blue Cross was –11% below that value, and United was –18% less.

Regardless of the improvements realized by both health plans, the fact remains that over 40% of the affected populations are not having this risk-factor for CAD controlled.

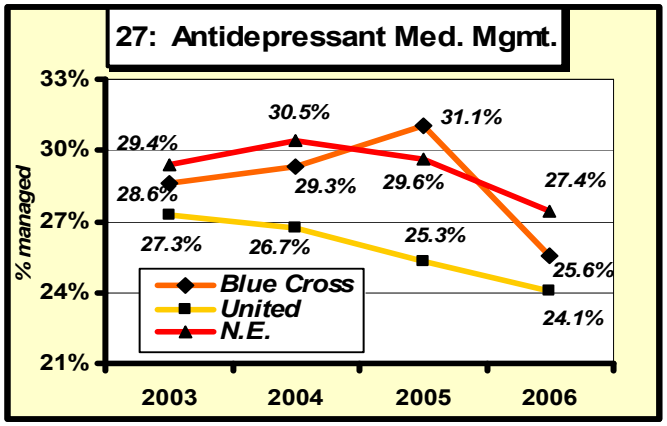
C. Appropriate Asthma Medications is the percentage of persistent asthmatic members (ages 5-56) prescribed the appropriate medications during the year (Chart 26). Asthma affects approximately 11% of Rhode Islanders, including 90,000 adults and 25,000 children. In 2005 and 2006, there were 1,511 hospital discharges where asthma was the primary diagnosis (in patients ages 5-56), 30% of which were covered by Blue Cross and United. Some of these admissions could be avoided had the disease been more effectively managed.

This measure is tracked by HEALTH's Asthma Control Program[18] as part of its efforts to improve the quality of asthma care and patient education to, in part, reduce asthma hospitalizations. The Program has adopted a target level of 95% compliance on this measure, so higher values on this measure are preferred.



Both Blue Cross and United performed well on this measure, with values virtually indistinguishable from each other and equivalent to the regional average in 2006. Also, that year, both plans were not significantly below the U.S. benchmark of 94.8% (i.e., less than –5% variances).

D. Antidepressant Medication Management measures the percentage of members (ages 18+) with a new episode of depression who received medication and at least three provider contacts within 12 weeks (Chart 27). Almost 19 million Americans suffer from a depressive disorder annually, and it is a major quality of life factor, with huge societal costs in terms of worker absenteeism and lost productivity. Therefore, higher values on this measure are preferred.



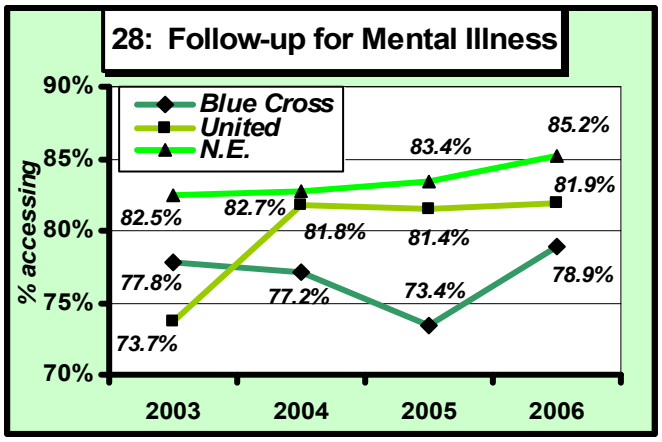
Blue Cross outperformed United by +6% on this measure in 2006. RI health plans' low values were matched by equally low regional values, so Blue Cross ended 7% below the N.E. average in 2006, and United was 12% below that comparable. In 2006, the U.S. benchmark was 31%, and both plans were below that value (i.e., 18% lower for Blue Cross and 22% lower for United).

There needs to be a concerted effort to improve this measure, when almost three quarters of affected plan members were not receiving the recommended behavioral health treatment.

VIII: ACCESS

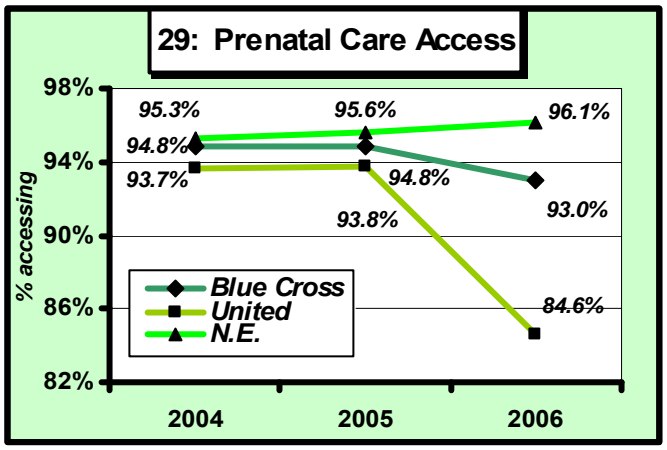
The statistics[5] in this section examine if members are obtaining needed services from the healthcare system. Access is one of the most difficult concepts to measure. It is more than simply making healthcare services available. Access means the right patients get the right care in the right amounts at the right time. Most of these measures are proxies for gauging access to particular services.

A. Follow-up for Mental Illness measures the percentage of members (ages 6+) who were discharged from hospitals for mental health treatment and received a follow-up visit within 30 days (Chart 28). Mental disorders affect ~57 million adult Americans and are a leading factor in suicides. Follow-up to hospitalization for mental illness is important in transitioning the patient out of the inpatient setting and for evaluating medications, so higher values on this measure are preferred.



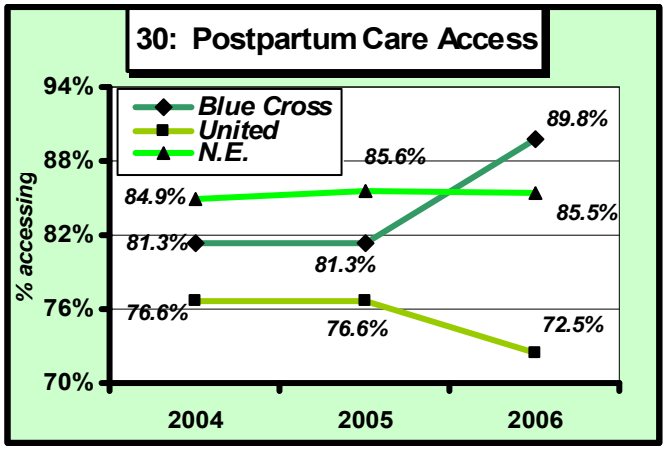
The plans' performances varied on this measure. Blue Cross posted declines in 2005, and then rebounded to end 7% below the New England average in 2006. United increased its value into 2004, and then leveled off to end not significantly less than the regional average (i.e., less than a –5% variance). The U.S. benchmark was 87.6% in 2006, and both plans were below that cutoff (i.e., 10% lower for Blue Cross and 6% lower for United).

B. Prenatal Care Access measures the percentage of women who delivered a live birth and had a prenatal visit in the first trimester (Chart 29). Prenatal care is preventive care, both in terms of avoiding poor outcomes and preparing the woman to become a mother, so higher values on this measure are preferred.



Blue Cross outperformed United by +10% on this measure in 2006. Both plans tracked the N.E. averages through 2005, and then diverged downward in 2006. That year, Blue Cross was not significantly lower than the regional comparable (i.e., less than a –5% variance), but United was 12% below that value. In 2006, the U.S. benchmark was 97.5%, and Blue Cross was not significantly below the benchmark (i.e., less than a -5% variance), but United was 13% below that value.

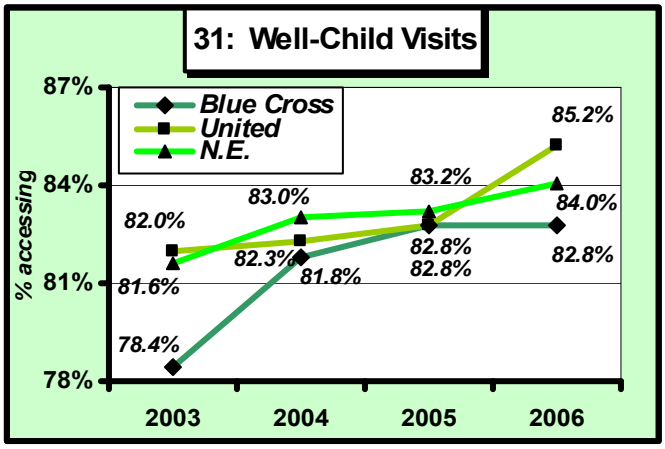
C. Postpartum Care Access measures the percentage of women who delivered a live birth and had a postpartum visit between 21-56 days after delivery (Chart 30). Postpartum care is essential in terms of evaluating the mother's physical and emotional well-being at a time of great stress and change. Therefore, higher values on this measure are preferred.



Blue Cross outperformed United by +24% on this measure in 2006. Both plans started the period below the regional average, and then diverged in 2006, with Blue Cross improving to a position 5% above the N.E. average, and United ending 15% below that value. The U.S. benchmark was 89.1% in 2006, and Blue Cross was among the best 10% of health plans nationally, while United was 19% short of that cutoff.

D. Well Child Visits measures the percentage of members (ages 3-6) who received a primary care visit during the year (chart 31). Well child visits are critical in detecting vision, speech and language problems early to help each child reach his or her full potential. Therefore, higher values on this measure are preferred.

This measure is tracked by HEALTH's Perinatal and Early Childhood Health Team[19] as part of its efforts to promote health among children birth to 6 years, and their families. The various programs within the Team target individual provider practices, so they have no adopted target level for this measure of statewide performance.

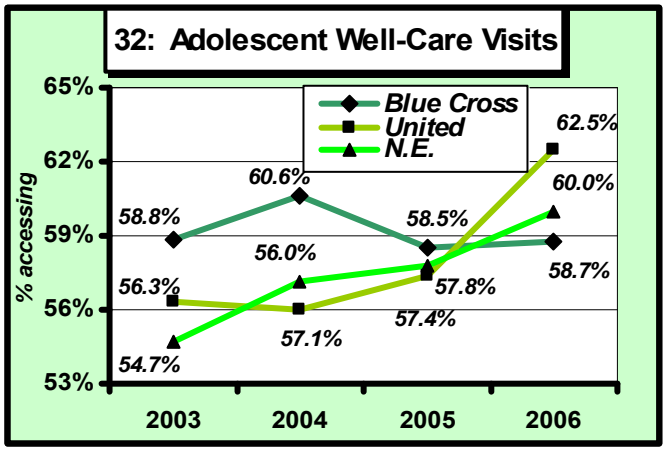


Both Blue Cross and United improved their values over time and ended the period not significantly different than the New England average in 2006. The U.S. benchmark was 83.3% in 2006 (i.e., less than the N.E. average), and United was among the best 10% of health plans nationally, while Blue Cross was not appreciably below that threshold (i.e., less than a –5% variance).

E. Adolescent Well-Care Visits measures the percentage of members (ages 12-21) who received a comprehensive well-care visit during the year (Chart 32). Well-care visits are key to

addressing the physical, emotional and social aspects of development in this population transitioning from childhood to adulthood. Therefore, higher values on this measure are preferred.

This measure is tracked by HEALTH's Initiative for Healthy Youth program[20] as part of its efforts to improve the health of adolescents through the development of medical homes. The program has adopted a target level of 75% compliance on this measure.



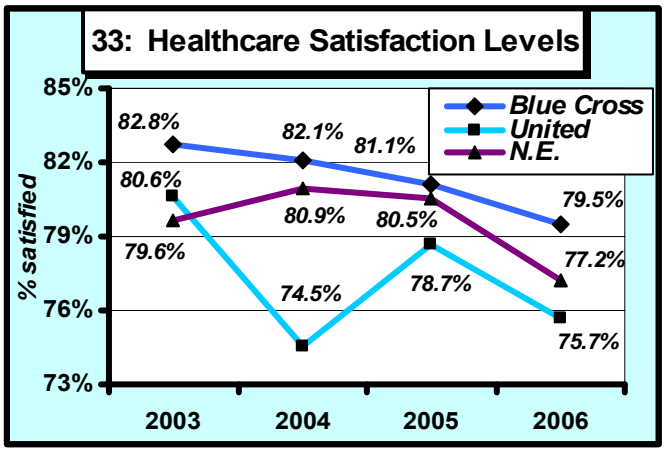
United outperformed Blue Cross by +6% on this measure in 2006. Similar to the *Well Child Visits*, both Blue Cross and United were not significantly different from the N.E. average in 2006 (i.e., less than +/-5% variances). The U.S. benchmark was 57.8% in 2006 (i.e., less than the N.E. average), and both plans were among the best 10% of health plans nationally, while United was significantly above that threshold (i.e., 8% higher).

Regardless of the favorable, relative performance of both health plans, 41% of Blue Cross' and 38% of United's target populations are not accessing these services on a timely basis.

IX: SATISFACTION

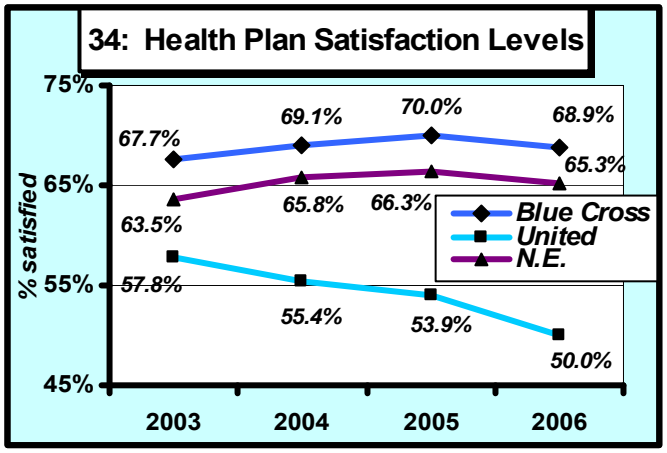
This section provides information[11] on the percentage of members who were satisfied with their experience of care, including both the healthcare services and the health plan itself.

A. Satisfaction with Healthcare is the percentage of members rating the healthcare services received in the past year as "excellent" or "very good" (Chart 33). This is a significant satisfaction measure in that it provides a composite score of overall satisfaction with all of the healthcare services a member receives. Perception is an important aspect of quality in that members must believe they are receiving quality services for them to be effectively provided, so higher values are preferred.



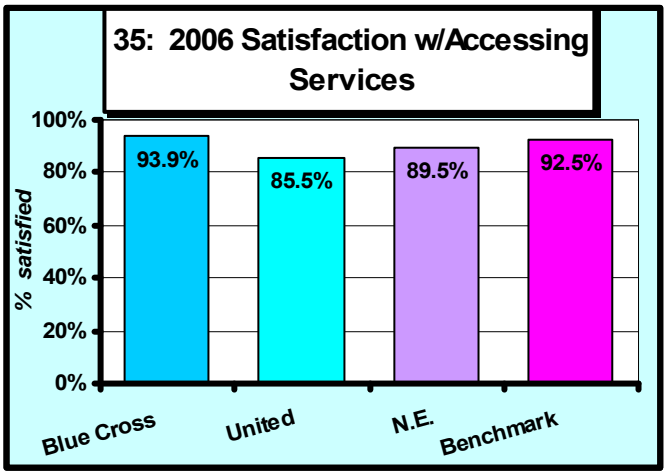
Blue Cross outperformed United by +5% on this measure in 2006. That year, neither plan was significantly different than the New England average (i.e., less than +/-5% variances). The national benchmark was 80% in 2006, and Blue Cross was not appreciable below that value (i.e., less than a –5% variance), while United was 5% below that threshold.

B. Satisfaction with Health Plans is the percentage of members rating the health plan as "excellent" or "very good" (Chart 34). This is another composite measure of satisfaction examining how members viewed the health plan itself. This measure and the previous one may be used as marketing and improvement tools indicating how the so-called 'customers' view the 'product'. Therefore, higher values are preferred.



Blue Cross outperformed United by +38% on this measure in 2006. That year, Blue Cross was 5% above the New England average, while United was 23% below that comparable. In 2006, the national benchmark was 73.2%, and both plans fell short of that cutoff (i.e., 6% lower for Blue Cross and 32% lower for United).

United exhibited a large discrepancy between its 2006 healthcare satisfaction level (75.7%), and its health plan satisfaction level (50%). Chart 35 illustrates one factor possibly contributing to this disparity. It graphs the members responding they were "usually" or "always" able to access the healthcare services they thought they needed in the past year.



Blue Cross outperformed United by +10% on this measure in 2006. Although United was not significantly below the N.E. average (i.e., less than a –5% variance), the perception of some of its members that services were not easily accessible could partially explain its 50% health plan satisfaction rate when the members were generally well satisfied with their healthcare services.

Appendix A. Blue Cross -RI Commercial Data

		2003		2004		2005		2006	
ENROLLMENT									
1	**RI Commercial Enrollment** *(RI member months/12)*	256,446		247,543		228,824		221,650	
2	**RI Commercial Market Shares**	63.7%		60.3%		64.9%		64.8%	
COSTS									
3	**Medical Expenses** *(per member per month)*	---		$238.35	1	$258.49	1	$269.67	1
4	**Administrative Expenses** *(per member per month)*	---		$36.53	1	$36.13	1	$38.57	1
5	**Profits** *(per member per month)*	---		$6.81	1	$7.32	1	$8.48	1
UTILIZATION									
6	**Hospital Discharges** *(per 1,000 members)*	56.7	2	58.6	2	56.8	2	56.6	2
7	**Hospital Days** *(per 1,000 members)*	248.9	2	248.8	2	225.4	2	220.8	2
8	**Average Length of Stay**	4.39	2	4.25	2	3.97	2	3.90	2
9	**ED Visits** *(per 1,000 members)*	196.9	2	190.9	2	195.6	2	194.1	2
10	**Mental Health Utilization** *(% accessing care)*	10.0%	2	10.1%	2	10.4%	2	10.4%	2
11	**Substance Abuse Utilization** *(% accessing care)*	---		1.01%	2	1.02%	2	1.07%	2
PREVENTION									
12	**Childhood Immunization** *(combo 2; to 2 yrs.)*	---		75.5%	3	79.8%	3	79.8%	5
13	**Adolescent Immunization** *(combo2; to 13 yrs.)*	---		63.2%	3	69.9%	3	69.9%	5
14	**Smokers Advised to Quit** *(18+ yrs.)*	77.0%	4	77.9%	4	75.5%	4	77.1%	4
15	**Smokers Advised on Cessation Meds** *(18+ yrs.)*	---		---		47.1%	4	49.8%	4
16	**Smokers Advised on Cessation Strategies** *(18+ yrs.)*	---		---		48.8%	4	54.2%	4
SCREENING									
17	**Colorectal Cancer Screening** *(51-80 yrs.)*	---		61.4%	3	62.3%	3	62.8%	3
18	**Breast Cancer Screening** *(52-69 yrs.)*	77.3%	3	75.2%	3	75.4%	3	76.7%	3
19	**Cervical Cancer Screening** *(21-64 yrs.)*	83.1%	3	82.7%	3	82.0%	3	83.0%	3
20	**Chlamydia Screening** *(16-25 yrs.)*	31.1%	3	34.6%	3	37.6%	3	39.6%	3
21	**Diabetic Eye Exams** *(18-75 yrs.)*	54.2%	3	59.2%	3	65.4%	3	64.0%	3
22	**Diabetic HbA1c Testing** *(18-75 yrs.)*	86.1%	3	90.4%	3	87.5%	3	93.6%	3
TREATMENT									
23	**Diabetic HbA1c Controlled** *(<7%; 18-75 yrs.)*	---		---		---		42.2%	3
24	**Hypertension Controlled** *(<140/90; 18-85 yrs.)*	---		---		---		65.2%	3
25	**Beta Blocker Treatment** *(after AMI; 35+ yrs.)*	93.0%	3	93.0%	5	96.9%	3	96.9%	5
26	**Cholesterol Controlled** *(LDL-C<100 mg/dL; 18-75 yrs.)*	---		51.1%	3	54.4%	3	59.1%	3
27	**Appropriate Asthma Medications** *(5-56 yrs.)*	---		---		92.3%	3	91.9%	3
28	**Antidepressent Med. Mgmt.** *(optimal contacts; 18+ yrs.)*	28.6%	3	29.3%	3	31.1%	3	25.6%	3
ACCESS									
29	**Follow-up for Mental Illness** *(w/in 30 days; 6+ yrs.)*	77.8%	3	77.2%	3	73.4%	3	78.9%	3
30	**Prenatal Care Access** *(w/in 1st trimester)*	---		94.8%	3	94.8%	5	93.0%	3
31	**Postpartum Care Access** *(w/in 21-56 days)*	---		81.3%	3	81.3%	5	89.8%	3
32	**Well-Child Visits** *(1st 15 months; 6+ visits)*	---		---		75.0%	3	82.3%	3
33	**Well-Child Visits** *(3rd-6th years)*	78.4%	3	81.8%	3	82.8%	3	82.8%	3
34	**Adolescent Well-Care Visits**	58.8%	3	60.6%	3	58.5%	3	58.7%	3
SATISFACTION									
35	**Satisfaction with Healthcare** *(Q.12; #s8-10)*	82.8%	4	82.1%	4	81.1%	4	79.5%	4
36	**Satisfaction with Health Plan** *(Q.42; #s8-10)*	67.7%	4	69.1%	4	70.0%	4	68.9%	4
37	**Satisfaction w/Accessing Services** *(Q.27)*	---		---		---		93.9%	4

Blank cells (without values), indicate that the measure was either not available (it was not yet developed by the NCQA), not reportable (it did not pass auditing standards), or not collected by HEALTH

[1] Source: The Health of RI's Health Insurers ~2006, Cryan, B., HEALTH/OHIC, June 2007, (Appx. B, p21)

[2] Sourced from HEDIS data, a combined rate (i.e., sum of the numerators over sum of the denominators) for Blue Cross' commercial PPO and HMO products

[3] Sourced from HEDIS data, a weighted-average (based on the eligible populations) of the values for Blue Cross' commercial PPO and HMO products

[4] Sourced from CAHPS data, a weighted-average (based on the RI commercial enrollments) of the values for Blue Cross' commercial PPO and HMO products

[5] Plan "rotated" the measure(s) (i.e., reported the previous year's values as allowed by the NCQA)

Appendix B. UnitedHealthcare -NE Commercial Data

		2003	2004	2005	2006
	ENROLLMENT				
1	**RI Commercial Enrollment** *(RI member months/12)*	71,277	70,232	59,140	49,891
2	**RI Commercial Market Shares**	17.7%	15.6%	16.8%	14.6%
	COSTS				
3	**Medical Expenses** *(per member per month)*	---	$170.01 [1]	$224.10 [1]	$234.57 [1]
4	**Administrative Expenses** *(per member per month)*	---	$45.66 [1]	$50.96 [1]	$55.54 [1]
5	**Profits** *(per member per month)*	---	$11.33 [1]	$12.78 [1]	$15.07 [1]
	UTILIZATION				
6	**Hospital Discharges** *(per 1,000 members)*	53.2	67.4	65.0	62.3
7	**Hospital Days** *(per 1,000 members)*	219.0	254.7	219.5	203.2
8	**Average Length of Stay**	4.12	3.78	3.37	3.26
9	**ED Visits** *(per 1,000 members)*	200.0	207.0	208.2	207.8
10	**Mental Health Utilization** *(% accessing care)*	8.6%	9.2%	8.8%	8.9%
11	**Substance Abuse Utilization** *(% accessing care)*	---	1.40%	1.29%	1.38%
	PREVENTION				
12	**Childhood Immunization** *(combo 2; to 2 yrs.)*	---	77.6%	79.6%	78.6%
13	**Adolescent Immunization** *(combo2; to 13 yrs.)*	---	74.9%	70.4%	71.0%
14	**Smokers Advised to Quit** *(18+ yrs.)*	83.8%	78.8%	81.6%	83.7%
15	**Smokers Advised on Cessation Meds** *(18+ yrs.)*	---	---	43.2%	47.5%
16	**Smokers Advised on Cessation Strategies** *(18+ yrs.)*	---	---	41.7%	60.0%
	SCREENING				
17	**Colorectal Cancer Screening** *(51-80 yrs.)*	---	58.9%	61.1%	61.1% [2]
18	**Breast Cancer Screening** *(52-69 yrs.)*	78.4%	77.4%	77.0%	77.4%
19	**Cervical Cancer Screening** *(21-64 yrs.)*	82.9%	82.5%	84.4%	82.5%
20	**Chlamydia Screening** *(16-25 yrs.)*	33.7%	36.8%	39.2%	38.9%
21	**Diabetic Eye Exams** *(18-75 yrs.)*	58.9%	58.6%	60.8%	63.3%
22	**Diabetic HbA1c Testing** *(18-75 yrs.)*	86.1%	88.6%	88.3%	89.8%
	TREATMENT				
23	**Diabetic HbA1c Controlled** *(<7%; 18-75 yrs.)*	---	---	---	38.9%
24	**Hypertension Controlled** *(<140/90; 18-85 yrs.)*	---	---	---	47.2%
25	**Beta Blocker Treatment** *(after AMI; 35+ yrs.)*	91.7%	98.2%	98.4%	98.4% [2]
26	**Cholesterol Controlled** *(LDL-C<100 mg/dL; 18-75 yrs.)*	---	40.1%	46.7%	54.0%
27	**Appropriate Asthma Medications** *(5-56 yrs.)*	---	---	91.9%	91.7%
28	**Antidepressent Med. Mgmt.** *(optimal contacts; 18+ yrs.)*	27.3%	26.7%	25.3%	24.1%
	ACCESS				
29	**Follow-up for Mental Illness** *(w/in 30 days; 6+ yrs.)*	73.7%	81.8%	81.4%	81.9%
30	**Prenatal Care Access** *(w/in 1st trimester)*	---	93.7%	93.8%	84.6%
31	**Postpartum Care Access** *(w/in 21-56 days)*	---	76.6%	76.6% [2]	72.5%
32	**Well-Child Visits** *(1st 15 months; 6+ visits)*	---	---	86.7%	86.7% [2]
33	**Well-Child Visits** *(3rd-6th years)*	82.0%	82.3%	82.8%	85.2%
34	**Adolescent Well-Care Visits**	56.3%	56.0%	57.4%	62.5%
	SATISFACTION				
35	**Satisfaction with Healthcare** *(Q.12; #s8-10)*	80.6%	74.5%	78.7%	75.7%
36	**Satisfaction with Health Plan** *(Q.42; #s8-10)*	57.8%	55.4%	53.9%	50.0%
37	**Satisfaction w/Accessing Services** *(Q.27)*	---	---	---	85.5%

Blank cells (without values), indicate that the measure was either not available (it was not yet developed by the NCQA), not reportable (it did not pass auditing standards), or not collected by HEALTH

[1] *Source: The Health of RI's Health Insurers ~2006, Cryan, B., HEALTH/OHIC, June 2007, (Appx. B, p21)*

[2] *Plan "rotated" the measure (i.e., reported the previous year's value as allowed by the NCQA)*

Appendix C. Blue Cross -MA Commercial Data

		2003	2004	2005	2006
	ENROLLMENT				
1	**RI Commercial Enrollment** *(RI member months/12)*	28,657	32,408	33,557	34,850
2	**RI Commercial Market Shares**	7.1%	8.5%	9.5%	10.2%
	COSTS				
3	**Medical Expenses** *(per member per month)*	---	$239.57 [1]	$265.02 [1]	$288.93 [1]
4	**Administrative Expenses** *(per member per month)*	---	$31.38 [1]	$33.99 [1]	$38.14 [1]
5	**Profits** *(per member per month)*	---	$11.62 [1]	$5.57 [1]	$1.47 [1]
	UTILIZATION				
6	**Hospital Discharges** *(per 1,000 members)*	49.6	51.9	51.9	53.6
7	**Hospital Days** *(per 1,000 members)*	209.0	213.7	214.4	211.0
8	**Average Length of Stay**	4.21	4.12	4.13	3.94
9	**ED Visits** *(per 1,000 members)*	204.0	199.5	208.7	214.4
10	**Mental Health Utilization** *(% accessing care)*	10.4%	10.9%	11.1%	11.5%
11	**Substance Abuse Utilization** *(% accessing care)*	---	1.00%	1.07%	1.24%
	PREVENTION				
12	**Childhood Immunization** *(combo 2; to 2 yrs.)*	---	86.2%	83.5%	87.3%
13	**Adolescent Immunization** *(combo2; to 13 yrs.)*	---	84.7%	92.1%	92.1% [2]
14	**Smokers Advised to Quit** *(18+ yrs.)*	73.1%	74.2%	79.7%	85.3%
15	**Smokers Advised on Cessation Meds** *(18+ yrs.)*	---	---	46.8%	54.8%
16	**Smokers Advised on Cessation Strategies** *(18+ yrs.)*	---	---	46.1%	50.0%
	SCREENING				
17	**Colorectal Cancer Screening** *(51-80 yrs.)*	---	63.8%	68.5%	69.4%
18	**Breast Cancer Screening** *(52-69 yrs.)*	83.1%	83.3%	82.2%	82.3%
19	**Cervical Cancer Screening** *(21-64 yrs.)*	89.0%	87.8%	87.8%	86.9%
20	**Chlamydia Screening** *(16-25 yrs.)*	39.8%	44.0%	46.7%	49.1%
21	**Diabetic Eye Exams** *(18-75 yrs.)*	63.5%	67.4%	74.7%	76.6%
22	**Diabetic HbA1c Testing** *(18-75 yrs.)*	89.5%	93.2%	93.2%	92.7%
	TREATMENT				
23	**Diabetic HbA1c Controlled** *(<7%; 18-75 yrs.)*	---	---	---	53.0%
24	**Hypertension Controlled** *(<140/90; 18-85 yrs.)*	---	---	---	68.4%
25	**Beta Blocker Treatment** *(after AMI; 35+ yrs.)*	96.8%	97.5%	99.5%	100.0%
26	**Cholesterol Controlled** *(LDL-C<100 mg/dL; 18-75 yrs.)*	---	60.1%	---	64.2%
27	**Appropriate Asthma Medications** *(5-56 yrs.)*	---	---	89.0%	89.6%
28	**Antidepressent Med. Mgmt.** *(optimal contacts; 18+ yrs.)*	38.7%	38.2%	37.8%	33.1%
	ACCESS				
29	**Follow-up for Mental Illness** *(w/in 30 days; 6+ yrs.)*	83.5%	84.3%	85.5%	87.5%
30	**Prenatal Care Access** *(w/in 1st trimester)*	---	98.0%	98.0% [2]	100.0%
31	**Postpartum Care Access** *(w/in 21-56 days)*	---	91.3%	91.3% [2]	89.8%
32	**Well-Child Visits** *(1st 15 months; 6+ visits)*	---	---	95.4%	95.4% [2]
33	**Well-Child Visits** *(3rd-6th years)*	89.5%	95.9%	92.4%	97.3%
34	**Adolescent Well-Care Visits**	69.2%	72.6%	71.9%	71.9% [2]
	SATISFACTION				
35	**Satisfaction with Healthcare** *(Q.12; #s8-10)*	79.9%	81.6%	80.4%	75.3%
36	**Satisfaction with Health Plan** *(Q.42; #s8-10)*	71.6%	74.0%	75.7%	70.2%
37	**Satisfaction w/Accessing Services** *(Q.27)*	---	---	---	92.2%

Blank cells (without values), indicate that the measure was either not available (it was not yet developed by the NCQA), not reportable (it did not pass auditing standards), or not collected by HEALTH

[1] *Source: RI Department of Business Regulation (extracted from the NAIC Health Database and an aggregate of the commercial product-lines of BCBS of MA, and BCBS of MA HMO Blue, Inc.)*

[2] *Plan "rotated" the measure (i.e., reported the previous year's value as allowed by the NCQA)*

Appendix D. New England Commercial Averages[1]

		2003	2004	2005	2006
	ENROLLMENT				
1	**RI Commercial Enrollment** *(RI member months/12)*	---	---	---	---
2	**RI Commercial Market Shares**	---	---	---	---
	COSTS				
3	**Medical Expenses** *(per member per month)*	---	$255.03 [2]	$264.85 [2]	$274.45 [2]
4	**Administrative Expenses** *(per member per month)*	---	$35.20 [2]	$38.05 [2]	$40.45 [2]
5	**Profits** *(per member per month)*	---	$10.41 [2]	$14.24 [2]	$9.60 [2]
	UTILIZATION				
6	**Hospital Discharges** *(per 1,000 members)*	51.4	52.0	51.7	52.2
7	**Hospital Days** *(per 1,000 members)*	198.0	195.2	195.2	189.8
8	**Average Length of Stay**	3.85	3.75	3.78	3.64
9	**ED Visits** *(per 1,000 members)*	197.0	195.7	210.8	217.6
10	**Mental Health Utilization** *(% accessing care)*	7.8%	8.3%	9.9%	9.1%
11	**Substance Abuse Utilization** *(% accessing care)*	---	0.84%	0.94%	1.05%
	PREVENTION				
12	**Childhood Immunization** *(combo 2; to 2 yrs.)*	---	76.1%	81.2%	82.3%
13	**Adolescent Immunization** *(combo2; to 13 yrs.)*	---	68.7%	77.4%	80.5%
14	**Smokers Advised to Quit** *(18+ yrs.)*	73.4%	74.4%	76.6%	78.5%
15	**Smokers Advised on Cessation Meds** *(18+ yrs.)*	---	---	47.7%	52.4%
16	**Smokers Advised on Cessation Strategies** *(18+ yrs.)*	---	---	47.8%	52.0%
	SCREENING				
17	**Colorectal Cancer Screening** *(51-80 yrs.)*	---	61.6%	63.6%	64.9%
18	**Breast Cancer Screening** *(52-69 yrs.)*	80.9%	80.1%	79.0%	78.8%
19	**Cervical Cancer Screening** *(21-64 yrs.)*	86.6%	86.0%	86.4%	85.7%
20	**Chlamydia Screening** *(16-25 yrs.)*	34.7%	37.4%	39.5%	44.4%
21	**Diabetic Eye Exams** *(18-75 yrs.)*	59.9%	64.1%	68.0%	68.7%
22	**Diabetic HbA1c Testing** *(18-75 yrs.)*	88.6%	90.5%	91.0%	91.5%
	TREATMENT				
23	**Diabetic HbA1c Controlled** *(<7%; 18-75 yrs.)*	---	---	---	---
24	**Hypertension Controlled** *(<140/90; 18-85 yrs.)*	---	---	---	63.1%
25	**Beta Blocker Treatment** *(after AMI; 35+ yrs.)*	97.2%	97.8%	98.1%	99.3%
26	**Cholesterol Controlled** *(LDL-C<100 mg/dL; 18-75 yrs.)*	---	53.7%	58.1% [3]	62.4%
27	**Appropriate Asthma Medications** *(5-56 yrs.)*	---	---	88.3%	91.6%
28	**Antidepressent Med. Mgmt.** *(optimal contacts; 18+ yrs.)*	29.4%	30.5%	29.6%	27.4%
	ACCESS				
29	**Follow-up for Mental Illness** *(w/in 30 days; 6+ yrs.)*	82.5%	82.7%	83.4%	85.2%
30	**Prenatal Care Access** *(w/in 1st trimester)*	---	95.3%	95.6%	96.1%
31	**Postpartum Care Access** *(w/in 21-56 days)*	---	84.9%	85.6%	85.5%
32	**Well-Child Visits** *(1st 15 months; 6+ visits)*	---	---	82.8%	85.1%
33	**Well-Child Visits** *(3rd-6th years)*	81.6%	83.0%	83.2%	84.0%
34	**Adolescent Well-Care Visits**	54.7%	57.1%	57.8%	60.0%
	SATISFACTION				
35	**Satisfaction with Healthcare** *(Q.12; #s8-10)*	79.6%	80.9%	80.5%	77.2%
36	**Satisfaction with Health Plan** *(Q.42; #s8-10)*	63.5%	65.8%	66.3%	65.3%
37	**Satisfaction w/Accessing Services** *(Q.27)*	---	---	---	89.5%

Blank cells (without values), indicate that the measure was either not available (it was not yet developed by the NCQA), not reportable (it did not pass auditing standards), or not collected by HEALTH

[1] *Unless otherwise stated, data are sourced from NCQA's Quality Compass, editions 2004-2007*

[2] *Source: The Health of RI's Health Insurers ~2006, Cryan, B., HEALTH/OHIC, June 2007, (Appx. B, p22); Note: these data are aggregates (i.e., totals) and not averages*

[3] *NCQA did not publish this data element so it has been generated by 'fitting' a data point to the 2004 and 2006 data*

Appendix E. National Commercial Benchmarks[1]

		2003	2004	2005	2006
ENROLLMENT					
1	**RI Commercial Enrollment** *(RI member months/12)*	---	---	---	---
2	**RI Commercial Market Shares**	---	---	---	---
COSTS					
3	**Medical Expenses** *(per member per month)*	---	---	---	---
4	**Administrative Expenses** *(per member per month)*	---	---	---	---
5	**Profits** *(per member per month)*	---	---	---	---
UTILIZATION					
6	**Hospital Discharges** *(per 1,000 members)*	---	---	---	---
7	**Hospital Days** *(per 1,000 members)*	---	---	---	---
8	**Average Length of Stay**	---	---	---	---
9	**ED Visits** *(per 1,000 members)*	---	130.9 [2]	138.4 [2]	138.9 [2]
10	**Mental Health Utilization** *(% accessing care)*	---	---	---	---
11	**Substance Abuse Utilization** *(% accessing care)*	---	---	---	---
PREVENTION					
12	**Childhood Immunization** *(combo 2; to 2 yrs.)*	---	81.7%	86.5%	87.7%
13	**Adolescent Immunization** *(combo2; to 13 yrs.)*	---	72.3%	81.0%	81.3%
14	**Smokers Advised to Quit** *(18+ yrs.)*	---	77.3%	78.4%	80.2%
15	**Smokers Advised on Cessation Meds** *(18+ yrs.)*	---	---	48.0%	53.0%
16	**Smokers Advised on Cessation Strategies** *(18+ yrs.)*	---	---	48.2%	52.8%
SCREENING					
17	**Colorectal Cancer Screening** *(51-80 yrs.)*	---	61.8%	63.5%	65.1%
18	**Breast Cancer Screening** *(52-69 yrs.)*	---	81.2%	80.1%	80.1%
19	**Cervical Cancer Screening** *(21-64 yrs.)*	---	87.2%	87.9%	87.1%
20	**Chlamydia Screening** *(16-25 yrs.)*	---	43.1%	45.5%	48.6%
21	**Diabetic Eye Exams** *(18-75 yrs.)*	---	66.2%	69.3%	71.2%
22	**Diabetic HbA1c Testing** *(18-75 yrs.)*	---	92.5%	92.7%	92.9%
TREATMENT					
23	**Diabetic HbA1c Controlled** *(<7%; 18-75 yrs.)*	---	---	---	---
24	**Hypertension Controlled** *(<140/90; 18-85 yrs.)*	---	---	---	68.1%
25	**Beta Blocker Treatment** *(after AMI; 35+ yrs.)*	---	100.0%	100.0%	100.0%
26	**Cholesterol Controlled** *(LDL-C<100 mg/dL; 18-75 yrs.)*	---	---	---	66.2%
27	**Appropriate Asthma Medications** *(5-56 yrs.)*	---	---	94.1%	94.8%
28	**Antidepressent Med. Mgmt.** *(optimal contacts; 18+ yrs.)*	---	31.9%	31.1%	31.0%
ACCESS					
29	**Follow-up for Mental Illness** *(w/in 30 days; 6+ yrs.)*	---	86.2%	86.4%	87.6%
30	**Prenatal Care Access** *(w/in 1st trimester)*	---	96.9%	97.1%	97.5%
31	**Postpartum Care Access** *(w/in 21-56 days)*	---	88.3%	89.0%	89.1%
32	**Well-Child Visits** *(1st 15 months; 6+ visits)*	---	---	85.9%	88.7%
33	**Well-Child Visits** *(3rd-6th years)*	---	82.8%	83.2%	83.3%
34	**Adolescent Well-Care Visits**	---	55.2%	55.0%	57.8%
SATISFACTION					
35	**Satisfaction with Healthcare** *(Q.12; #s8-10)*	---	83.4%	83.4%	80.0%
36	**Satisfaction with Health Plan** *(Q.42; #s8-10)*	---	73.9%	75.3%	73.2%
37	**Satisfaction w/Accessing Services** *(Q.27)*	---	---	---	92.5%

Blank cells (without values), indicate that the measure was either not available (it was not yet developed by the NCQA), not reportable (it did not pass auditing standards), or not collected by HEALTH

[1] Benchmarks are the 'best' 10% of health plans nationally (i.e., the 90th percentile values, because higher values are preferred), and are sourced from NCQA's Quality Compass, editions 2005-2007

[1] Benchmarks are the 'best' 10% of health plans nationally (i.e., the 10th percentile values, because lower values are preferred), and are sourced from NCQA's Quality Compass, editions 2005-2007

Endnotes:

1 *Blue Cross and Blue Shield of Massachusetts, domiciled in Massachusetts, is included in this group and its performance data are included in Appendix C (but not analyzed in the body of the report), and United Healthcare Insurance Company (UHIC), a Connecticut domiciled insurer and 'sister' corporation to UnitedHealthcare of NE (UHCNE), is also included in this group but its data were not included because it was granted a waiver from reporting separate HEDIS and CAHPS measures from HEALTH's Office of Managed Care Regulation (i.e., for 32 of the 37 measures collected, its data are identical to that for UHCNE). UHIC had the following RI members: 13,279, 11,652, and 22,738 for 2004-2006, respectively. All other health plans in this group had fewer than 10,000 fully-insured RI members, and were exempt from filing any data (to reduce their reporting burdens). In addition, this report excludes members enrolled in self-insured plans administered by these and other carriers that are exempt from state regulation.*

2 *Confidence intervals could not be calculated for Blue Cross' clinical and access measures because they are a composite of the HEDIS and CAHPS values for its commercial PPO and HMO products (see endnotes 6 and 11), so differences (between health plans and the N.E. RI values and the U.S. benchmarks) that are less than +/-5% are considered to be too small to be statistically meaningful*

3 *e.g., 'gatekeepers', second opinions, formularies, restricted networks, etc.*

4 *For ED Visits measure in which lower values are preferred, the benchmark is the 10th national percentile value*

5 *Source: The Health of RI's Health Insurers (2006), HEALTH/OHIC, Cryan, B., June 2007, Appx. B*

6 *These values are sourced from HEDIS data. HEDIS (Health Plan Employer Data and Information Set) is a set of performance measures for the health insurance industry, administered by the National Committee for Quality Assurance (NCQA). The values reported for BCBSRI (Blue Cross –RI) are a weighted-average (based on the eligible populations) of the individual HEDIS values reported for its commercial PPO and HMO products. For the utilization measures in Section V (Utilization), the values reported for BCBSRI (Blue Cross –RI) are a combined rate (i.e., sum of the numerators over the sum of the denominators) of the individual HEDIS rates reported for its commercial PPO and HMO products.*

7 *So-called Combo 2 immunizations include: four DTaP/DT, three IPV, one MMR, three HIB, three hepatitis B, and one VZV vaccination*

8 *For more information contact Patricia Raymond, RN at 401-222-5921, patricia.raymond@health.ri.gov; see also http://www.health.ri.gov/immunization/data/ChildhoodVaccinationCoverageReport.pdf*

9 *http://www.cdc.gov/nip/recs/child-schedule.htm.*

10 *In addition to the vaccinations in endnote,[7] includes: the 2nd MMR, three hepatitis B, and one VZV vaccination*

11 *These values are sourced from CAHPS data. CAHPS (Consumer Assessment of Healthcare Providers & Systems) is a set of standardized surveys administered by the NCQA. The values reported for BCBSRI (Blue Cross –RI) are a weighted-average (based on RI membership) of the individual CAHPS values reported for its commercial PPO and HMO products.*

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